APPOINTMENT OF REPRESENTATIVE—ESTATE RECOVERY

If you want your attorney, or another individual, to assist you with the application process for an Estate Recovery claim exemption, and to receive information from the California Department of Health Services, you **must** complete this form.

SECTION I. To be completed by the Applicant.

Name of applicant | Date

Case number or social security number ***(optional)***

I APPOINT THIS INDIVIDUAL _____ / _____
Name of individual as representative | Relationship or name of organization

Representative's complete address | Telephone number

AS MY AUTHORIZED REPRESENTATIVE TO ACCOMPANY, ASSIST, AND REPRESENT ME IN MY APPLICATION FOR AN ESTATE RECOVERY CLAIM EXEMPTION AS A BLIND OR DISABLED CHILD OF THE DECEDENT.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:
- Submit requested verifications to the Department of Health Services, Estate Recovery Unit, and the Department of Social Services, Disability and Adult Programs Division;
- Obtain information from the Department of Health Services, Estate Recovery Unit, and the Department of Social Services, Disability and Adult Programs Division;
- Accompany me to any required face to face interview(s);
- Provide any medical records and other information regarding my medical problem(s) and limitation(s) to the Department(s);
- Receive a copy of the disability determination decision, mailed from the Department of Health Services, Estate Recovery Unit.

I UNDERSTAND THAT I CONTINUE TO HAVE RESPONSIBILITY TO:
- Complete and sign the Applicant's Supplemental Statement of Facts for Medi-Cal (MC 223);
- Attend and participate in any required face to face interviews;
- Sign the Authorization for Release of Information (MC 220) for each doctor or medical facility listed in the Applicant's Supplemental Statement of Facts for Medi-Cal (MC 223);
- Provide all requested verifications before my application for an Estate Recovery claim exemption can be determined;
- Accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:
- Choose anyone I wish to be my authorized representative;
- Revoke this appointment at any time by notifying the Collection Representative at the Department of Health Services, Estate Recovery Unit.

Applicant's signature | Date

➤

Applicant's complete address

SECTION II. To be completed by the Authorized Representative named. *Law firms, organizations, and groups may represent the applicant, but an individual must be designated as the contact person to act on the applicant's behalf.*

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:
- The applicant may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have ***no*** other power to act on behalf of the applicant, except as stated above;
- I may ***not*** act in lieu of the applicant;
- I may not transfer or resign my appointment without a new Appointment of Representative form being completed by the applicant.

I CERTIFY THAT:
- I have not been suspended or prohibited from practice before the Social Security Administration;
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative;
- I am known to be of good character.

This authorization expires upon a final disability determination.

Authorized representative's signature | Date

➤

PRIVACY STATEMENT

The Information Practices Act of 1977 (California Civil Code, Section 1798.1, et. seq.) and the Federal Privacy Act of 1974 (Title 5, United States Code, Section 552a, et. seq.) require that this notice be provided when collecting personal information from individuals. This information is being collected pursuant to Welfare and Institutions Code, Section 14009.5, and Title 22, California Code of Regulations, Sections 50960, et. seq. The primary use for the information is to determine if the applicant meets the criteria of blind or disabled, as established in 42 United States Code, Section 1382c. All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the disability claim. The Department does not have any known or foreseeable disclosures that may be made of the information. The applicant has a right of access to records containing personal information maintained by the Department. The person responsible for the system of records for information obtained from the application is the Chief, Third Party Liability Branch, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.